



DEPARTMENT OF VETERANS AFFAIRS OFFICE OF INSPECTOR GENERAL

PODCAST TRANSCRIPT

Two Reports on Deficiencies in Care at the Ralph H. Johnson VA Medical Center in Charleston, South Carolina

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Introduction:

Hello listeners! Thank you for listening to this companion podcast produced by the Department of Veterans Affairs Office of Inspector General. Companion podcasts summarize and increase awareness of VA OIG published reports and regularly feature those OIG employees who conducted the report, inspection, or investigation. Find all VA OIG podcasts online at va.gov/oig.

Dr. Amber Singh:

This is Dr. Amber Singh. I am associate director of mental health programs within the VA Office of Inspector General. I'm here with Nhien Dutkin, mental health system specialist.

Nhien, we are here to discuss two reports regarding the care of a patient at the Ralph H. Johnson VA Medical Center in Charleston, South Carolina. The two reports are [*Deficiencies in Mental Health Care Coordination and Administrative Processes for a Patient Who Died by Suicide*](#) and [*Deficiencies in the Management of a Patient's Reported Intimate Partner Violence*](#).

These two reports discuss different aspects of the care provided to a patient who died by suicide. The VA has identified suicide prevention as the top clinical priority. Before we discuss this particular patient's care, can you provide some general information about the suicide rates in the United States?

Nhien Dutkin:

Hello Amber. Thank you for inviting me here today. The VA recently published the 2021 National Veteran Suicide Prevention Annual Report, which provides information about suicide from 2001 through 2019. In the United States, adult deaths by suicide increased from 29,580 in 2001 to 45,861 in 2019. Veterans accounted for about 14 percent of all deaths by suicide, and approximately 17 veterans died by suicide each day in 2019.

Dr. Amber Singh:

Those are sobering statistics. What is VA doing to enhance its suicide prevent efforts?

Nhien Dutkin:

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In 2018, VA implemented the National Strategy for Preventing Veteran Suicide, which includes a 10-year vision to end veteran suicide. The strategy focuses on prevention and intervention, as well as short- and long-term support for individuals who have experienced bereavement after a death by suicide. For example, VA has started a program to identify patients who are at statistically increased risk for adverse outcomes, including suicide and overdose. The program is called Recovery Engagement and Coordination for Health—Veterans Enhanced Treatment Program or REACH VET.

Dr. Amber Singh:

Thanks for sharing that information. Let's talk about the two reports concerning the mental health treatment of a patient who later died by suicide. I understand that the OIG received a request from House Committee on Veterans Affairs Chairman Mark Takano to review a complaint about this patient's care. Would you please tell us about the patient and the care the facility staff provided?

Nhien Dutkin:

Certainly. The patient had a history of treatment with antidepressant and mood stabilizer medications when the patient initiated primary care at the facility in 2019. The primary care physician immediately referred the patient for mental health treatment including medication management.

Dr. Amber Singh:

Then what happened?

Nhien Dutkin:

About a month and a half later, the patient called the Veterans Crisis Line and was admitted to the facility's Inpatient Mental Health Unit. Staff completed a safety plan and discharged the patient with two follow-up appointments after six days on the inpatient unit. The patient then participated intermittently in outpatient mental health treatment.

Approximately one month after their last outpatient mental health appointment, the patient left the outpatient social worker a voicemail message that hinted that they were not doing well. The social worker returned the call but was unable to leave a voicemail message because the patient's voicemail was not working. The patient died by suicide four days after leaving the social worker the voicemail.

Dr. Amber Singh:

That is tragic. Did staff respond appropriately to the patient's voicemail?

Nhien Dutkin:

The social worker attempted to contact the patient once. Despite documenting a plan to call again to ascertain the patient's safety, the social worker did not attempt to reach the patient again. In an interview with the OIG team, the social worker explained not reaching out to the patient because the patient

discontinued treatment about two months earlier and the social worker did not think there was an immediate safety concern.

Dr. Amber Singh:

What did you determine about the staff's response to the patient's voicemail?

Nhien Dutkin:

We concluded that the lack of reaching out to the patient at that time may have contributed to a missed opportunity to evaluate the patient's suicide risk and treatment needs and to re-engage the patient in care.

Dr. Amber Singh:

The complaint that prompted this inspection included a concern that patients in need of mental health care were not being treated appropriately. What did the team find?

Nhien Dutkin:

Yes, the complaint alleged that care coordination procedures between primary care and mental health services resulted in inadequate psychiatric monitoring of the patient as well as delays in referral of primary care patients for psychiatric care.

We did not find evidence of inadequate psychiatric monitoring of the patient whose care we reviewed. The primary care physician did refer the patient for a mental health assessment. A psychologist assessed the patient the same day and referred the patient to general mental health services where they received continuous psychiatric medication management.

Dr. Amber Singh:

What else did your inspections reveal?

Nhien Dutkin:

In interviews and a survey of mental health and primary care services, facility leaders and staff did not report that the primary care procedures for care coordination with mental health services contributed to delays for patients being referred for psychiatric treatment.

Dr. Amber Singh:

The team also reviewed the complainant's concern about staff delaying the assignment of a high-risk for suicide patient record flag in the patient's electronic health record. Could you explain the process and purpose of the high-risk for suicide patient record flag?

Nhien Dutkin:

Certainly. When a high-risk for suicide patient record flag is assigned, an alert in the patient's electronic health record informs staff who access the record that the patient may be presenting with immediate safety concerns. The suicide prevention coordinator is required to activate the flag within 24 hours of determining it is indicated and must conduct a review every 90 days to determine whether to continue or inactivate the high-risk for suicide patient record flag.

Dr. Amber Singh:

So this patient was assigned a high-risk for suicide patient record flag while on the facility's inpatient mental health unit and within 24 hours as required, is that right?

Nhien Dutkin:

Yes, however, we did identify an important concern. We found that staff did not evaluate the patient's condition and treatment needs and staff did not reach out to the patient as part of their review.

Dr. Amber Singh:

Why is that significant?

Nhien Dutkin:

We would have expected staff to attempt to contact the patient given the patient's high risk for suicide status, substance use, diminished engagement in treatment, and a recent troubling voicemail message. In addition, the suicide prevention coordinator continued the high-risk for suicide patient record flag unknowingly after the patient's death by suicide.

Dr. Amber Singh:

In your report, you describe concerns about the assignment of a mental health treatment coordinator for the patient. The mental health treatment coordinator is a mental health clinician who serves as a point of contact during care transitions, such as going from inpatient to outpatient treatment. Veterans Health Administration (referred to as VHA) requires staff to assign every patient a mental health treatment coordinator prior to discharge from an inpatient mental health unit. What happened with the assignment of a mental health treatment coordinator for this patient?

Nhien Dutkin:

At the time of the patient's care, there was no facility policy to guide staff's identification and assignment of mental health treatment coordinators. Staff did not assign the patient's mental health treatment coordinator until 15 days after the patient was discharged from the inpatient mental health unit. The lack of facility policy may have contributed to staff not completing this assignment prior to the patient's discharge. Without a mental health treatment coordinator, the patient may not have received support for the transition to outpatient care.

Dr. Amber Singh:

You also identified an issue related to the follow through with the REACH VET program requirements that you mentioned earlier. About a month after the patient's discharge from the inpatient mental health unit, the patient was identified through REACH VET. What is expected when a patient is identified through REACH VET?

Nhien Dutkin:

The REACH VET provider assigned to the patient is expected to complete a comprehensive review of the patient's treatment plan, contact the patient to collaboratively review their mental health care, and determine if there are opportunities for enhanced treatment.

Dr. Amber Singh:

And what happened in this patient's case?

Nhien Dutkin:

The REACH VET provider did not discuss the REACH VET program with the patient and explain the patient's elevated risk for adverse outcomes. We emphasize that this was a missed opportunity to speak with the patient about risks such as suicide and treatment options. If the REACH VET provider had held this conversation with the patient, this may have provided the patient an opportunity to talk about stressors and other risk factors that had not been identified earlier.

Dr. Amber Singh:

Speaking of risk factors, the report also identified deficiencies related to suicide risk screening and assessment. Specifically, you found deficiencies in the facility staff's compliance with VHA requirements that inpatient mental health unit staff complete a suicide risk screen within 24 hours prior to the patient's discharge.

Nhien Dutkin:

Yes, facility staff did not complete the suicide risk screen as required, which may have contributed to an underestimation of the patient's risk and a missed opportunity to develop a safety plan to mitigate the patient's specific risks.

Dr. Amber Singh:

The report also discusses deficiencies in staff's notification to facility leaders of the patient's death by suicide.

Nhien Dutkin:

Yes, it does. Staff did not notify facility leaders or suicide prevention staff about the patient's death by suicide. A medical records clerk at the facility received the patient's death certificate from an Army Reserve investigating officer who requested the patient's medical records to uncover factors that contributed to the patient's death by suicide approximately two months earlier.

Dr. Amber Singh:

Does the VA have a policy on reporting deaths by suicide?

Nhien Dutkin:

Yes and no. VHA implemented a standardized process for *clinical* staff to report all deaths by suicide, but there was no VHA guidance for *non-clinical* staff, such as the medical records clerk. Leaders in VHA's Office of Mental Health and Suicide Prevention told us that the facility should have a policy that guides suicide notification processes for non-clinical staff.

Dr. Amber Singh:

Although facility leaders didn't have a policy in place at the time of the patient's death, I understand that in October 2020 they implemented a process that included Decedent Affairs staff notifying the suicide prevention team of any death of a patient who was assigned a high-risk for suicide patient record flag. Is that right?

Nhien Dutkin:

Yes, that's right. However, we would expect all staff to be required to notify facility leaders of patient deaths by suicide regardless of whether the patient was assigned a high-risk-for-suicide patient record flag. We want to make sure that facility leaders are notified of all patient deaths by suicide for two reasons. First, we want to make sure that facility leaders follow up with a patient's family in a timely manner to offer condolences and provide supportive resources. We also want to ensure that there is a timely review of the patient's care and circumstances so that facility and VHA leaders can learn from the tragedy and institute policies and practices to reduce the chances of other patient deaths by suicide.

Dr. Amber Singh:

The facility director concurred with four of the five recommendations in this report and provided sufficient evidence to close the recommendations related to mental health treatment coordinator assignment and notification of patient deaths by suicide. However, the director non-concurred with a recommendation related to REACH VET program requirements. Can you tell us more about that?

Nhien Dutkin:

The director acknowledged that the provider inadvertently documented that the patient was informed of the REACH VET status and asserted that they met the "full intent of the REACH VET initiative." While

the director accurately noted that one purpose of the REACH VET program is to identify at-risk veterans not engaged in VHA services, the REACH VET program has additional goals. These include providers' collaborative review of patients' mental health conditions and risk factors as well as meeting with patients to strengthen the therapeutic relationship. In our view, the failure of the REACH VET provider to take advantage of the opportunity to work collaboratively with the patient was especially unfortunate since the patient was high risk and difficult to engage in treatment.

Dr. Amber Singh:

Those are such important considerations with respect to improving care for veterans at risk of suicide. Thanks for explaining this investigation.

Before you go, I would like to talk briefly about a different report that investigated another aspect of this patient's care.

Nhien Dutkin:

Sure.

Dr. Amber Singh:

In the second investigation, the team reviewed staff's management of reports of intimate partner violence (or IPV) from the patient and the patient's spouse. Intimate partner violence involves acts of aggression by a current or former spouse or partner, and can include physical violence, nonconsensual sexual acts, stalking, and psychological aggression. To address this serious problem, VHA implemented an IPV Assistance Program directive in January 2019. What does this mean for individual VA facilities?

Nhien Dutkin:

The IPV Assistance Program requires that services including assessment and intervention are offered to veterans, their intimate partners, and VA employees affected by IPV. Every VA medical center is also required to have an assigned IPV Assistance Program point of contact as a subject matter expert and to provide education, assessment, intervention, and resources to staff and patients affected by IPV.

Dr. Amber Singh:

Can you tell us about the reports of intimate partner violence associated with this case?

Nhien Dutkin:

Yes. Both the patient and spouse made reports of IPV over the course of the patient's inpatient admission and during subsequent outpatient care. However, the patient's electronic health record did not include documentation that any inpatient or outpatient staff discussed the reported IPV with the IPV Assistance Program point of contact.

This may have contributed to a failure to provide the patient and spouse with IPV resources and offer treatment options in response to the patient's reported IPV, as we would have expected.

Dr. Amber Singh:

You also discuss an inpatient provider's failure to complete a progress note addendum within 24 hours, as required by facility policy. Why is that significant?

Nhien Dutkin:

In the addendum, the provider documented information that was not included in other notes. Specifically, the addendum included specific information from the patient's spouse about the severity of the IPV and the spouse's fears that the patient would continue the abusive behaviors after being discharged. This information was not available to other clinicians until the provider signed the progress note addendum 34 days after contact with the patient's spouse, which may have contributed to staff not providing IPV resources and interventions for the patient and the spouse.

Dr. Amber Singh:

Can you tell me about implementation of the IPV Assistance Program at this facility?

Nhien Dutkin:

We found that the facility director did not ensure development of a protocol, as required. However, in September 2020, after we initiated this healthcare inspection and 19 months after it was required, the facility's chief of the social work service developed a protocol.

Dr. Amber Singh:

In your report, you emphasize that the IPV Assistance Program directive states that staff who conduct IPV screening should receive "skills-based" training and that IPV Assistance Program coordinators are responsible for providing trainings, including at new employee orientation. However, the directive also states that there are no formal national mandatory training requirements. That is confusing.

Nhien Dutkin:

Yes, we did find the directive's guidance on training to be confusing. We also worried that this lack of clarity regarding training requirements may contribute to inadequate staff training, deficient IPV screening, and ultimately inadequate resources offered to IPV perpetrators and victims.

Dr. Amber Singh:

The report also highlights concerns related to consultation with the Office of Chief Counsel regarding mandatory reporting responsibilities. What are the expectations for reporting IPV to legal authorities?

Nhien Dutkin:

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Mandatory reporting requirements vary by state. VHA advises employees to work with their Office of Chief Counsel to determine the state reporting requirements for victims of IPV.

Dr. Amber Singh:

The Ralph H. Johnson VA Medical Center is in South Carolina. What are the reporting requirements in that state?

Nhien Dutkin:

In the state of South Carolina, providers are mandated to report abuse of a vulnerable adult. Given the patient's homicidal ideation, reports of IPV by both the patient and spouse, and the severity of the reported IPV, we would have expected inpatient staff to consider consultation with the Office of Chief Counsel to determine if the patient's spouse was considered a vulnerable adult and definitively identify reporting responsibilities.

Dr. Amber Singh:

And what did your inspection find?

Nhien Dutkin:

Although we could not determine whether Office of Chief Counsel consultation would have resulted in a report to the state, failure to determine reporting responsibilities could contribute to state agencies not having adequate information to provide advocacy and protection for IPV victims.

Dr. Amber Singh:

In the report, you made one recommendation to the Under Secretary for Health related to providing clear guidance regarding IPV Assistance Program training requirements, and the Under Secretary concurred. The facility director concurred with the other three recommendations and provided sufficient evidence to close recommendations related to staff's consultation with IPV Assistance Program and Office of General Counsel. However, the OIG noted concerns about the director's comments regarding the recommendations related to IPV reporting requirements and timely documentation.

Nhien Dutkin:

Yes, we fundamentally disagree with the director's assertion that there was no question regarding IPV reporting requirements in this patient's situation. Given the mandatory reporting of abuse of a vulnerable adult and ambiguity about whether the patient's spouse was considered a vulnerable adult, we would expect staff to have consulted with Office of General Counsel about whether to report.

Similarly, in response to the recommendation regarding resident physicians' timely documentation, the director commented that all critical information was in other notes. We disagree and emphasize that the

documentation reflects the severity of the IPV and that this information was only available in the note that remained inaccessible for 34 days.

Dr. Amber Singh:

Nhien, thank you for walking us through these two important reports. VA has submitted actions plans to address the deficiencies, and the OIG will follow up on the planned actions until they are completed.

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